

Participant Signature

DIRECT DEPOSIT AUTHORIZATION FORM

Date

Employer Name																											
Participant First Name										_	MI		Last	Nar	Name					-						-	
Addı	ress						•	•		•		•					•	•		•	•	•		•		•	
City State Zip																											
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Emai	il Ad	dres	ss					<u> </u>						<u> </u>			<u> </u>	J				j					
Social Security Number Phone Number																											
Please check one:																											
☐ Set up new Direct Deposit									[☐ Change Direct Deposit									☐ Cancel Direct Deposit								
Bank Account Information: Type of Account: (Please check one) Checking (Please check one) You must attach a voided check with pre-printed MICR account information, or a letter or form from the Bank certifying the ABA number, Account number and MICR information. Savings You must attach a letter or form from the Bank certifying the ABA number, Account number and MICR information. Name of Bank: Transit ABA Routing #: Account #: (Please allow 10 business days after receipt by Capital Financial Group, Inc. for bank pre-notification to be complete)																											
 Direct Deposit is available only if your employer uses Electronic Funds Transfer. Please be sure to provide your SSN or Member ID. Mail to: Capital Financial Group, Inc. 89 Saratoga Avenue South Glens Falls, New York 12803 Or fax to: (518) 798-7502 Call Capital Financial Group, Inc. with questions at (518) 793-2885 																											
By submitting this form, I hereby authorize Capital Financial Group, Inc. to deposit my reimbursements directly into the bank account indicated above and, if necessary, to withdraw amounts from the account in order to adjust for any amounts erroneously deposited. This authorization will remain in effect until Capital Financial Group, Inc. receives written notice from me of its termination.																											